

**KEEPING THE PROMISE: HOW BETTER MANAGING
MEDICARE CAN PROTECT SENIORS' BENEFITS
AND SAVE THEM MONEY**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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**KEEPING THE PROMISE: HOW BETTER
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MONEY?**

TUESDAY, MARCH 4, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Shimkus, Murphy, Gingrey, Bilirakis, Pallone, Barrow, Christensen, and Waxman (ex officio).

Staff Present: Clay Alspach, Counsel, Health; Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Sydne Harwick, Legislative Clerk; Sean Hayes, Counsel, O&I; Katie Novaria, Legislative Clerk; Christopher Pope, Fellow, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Ziky Abablya, Minority Staff Assistant; Kaycee Glavich, Minority GAO Detailee; Amy Hall, Minority Senior Professional Staff Member; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair will recognize himself for an opening statement.

In fiscal year 2014, the Medicare program will cover nearly 54 million Americans, and the Congressional Budget Office, CBO, estimates that total Medicare spending will be approximately \$603 billion, \$591 billion of which will be spent on benefits. According to the Department of Health and Human Services fiscal year 2013 Agency Financial Report, the improper payment rate for Medicare fee-for-service, FFS, was 10.1 percent last year.

Adding in the improper payments for Parts C and B with error rates of 11.4 percent and 3.1 percent respectively, improper payments totaled over \$49.8 billion. Independent estimates of the real costs of waste, fraud and abuse in Medicare are much higher.

Why are these figures important? The Medicare Trust Fund is set to go bankrupt sometime in the next decade. Absent congressional action, the Congressional Research Service, CRS, has stated Part A benefits cannot be paid out while the trust fund is insolvent. That is simply unacceptable. We cannot afford a future where our seniors' hospital bills go unpaid. Every taxpayer dollar must be protected.

Some of my colleagues have suggested that merely eliminating the multibillion dollar losses due to inefficiency and fraud will alone fix the insolvency problem. That claim is, frankly, false. While reducing waste, fraud, and abuse, and managing the program more effectively, should be an administration priority, that alone is not enough to address Medicare's spending problem. However, critics are correct that a congressional solution is needed. We must do everything in our power to safeguard the money in the trust fund until such time as Congress accepts its responsibility to make structural changes to save the program for the millions who depend on it.

Medicare uses a variety of contractors to assist in paying provider claims, delivering benefits and carrying program integrity and oversight functions. Many of these contractors have valuable experience fighting fraud efficiently managing health insurance programs. Yet sometimes Federal law or administrative barriers prevent us from using their expertise to prevent waste, fraud, and mismanagement in the Medicare program. Other times, all that is missing is a dose of common sense and leadership.

This committee has, for years, studied the problem and reviewed potential new programs to help CMS fight waste, fraud, and abuse. This is not one of these hearings. Today's hearing is an opportunity to hear from experts about the challenges CMS faces in administering the program. In fact, today's hearing is a first step toward a broader long-term effort to build consensus about the best ways to modernize the Medicare program in its management, operations, and accountability. And the best way to strengthen Medicare is to help improve and modernize the business model of the agency that oversees the Medicare program, CMS.

The purpose of today's hearing is to examine how CMS currently uses and oversees these contractors to lessen program vulnerabilities and protect seniors' benefits by increasing accountability and cost-effectiveness. Long term, I hope to work with my colleagues to identify barriers in Federal law and within CMS itself that prevent contractors from fighting waste, inefficiency, fraud, and abuse, and I hope we will address them.

I am pleased to have witnesses from both GAO and the HHS OIG with us today to discuss the types and functions of Medicare contractors and how the program can better manage them to meet its goals. I would note that the HHS OIG is releasing two new reports today on these topics, and I look forward to the testimony of all of our witnesses.

With that, I will yield back and recognize the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The chair will recognize himself for an opening statement.

In Fiscal Year 2014, the Medicare program will cover nearly 54 million Americans, and the Congressional Budget Office (CBO) estimates that total Medicare spending will be approximately \$603 billion; \$591 billion of which will be spent on benefits.

According to the Department of Health and Human Service's (HHS) FY2013 Agency Financial Report, the improper payment rate for Medicare fee-for-service (FFS) was 10.1% last year. Adding in the improper payments for Parts C and D, with error rates of 11.4% and 3.1%, respectively, improper payments totaled over \$49.8 billion.

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Why are these figures important?

The Medicare Trust Fund is set to go bankrupt sometime in the next decade. Absent Congressional action, the Congressional Research Service (CRS) has stated Part A benefits cannot be paid out while the Trust Fund is insolvent.

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That claim is, frankly, false.

While reducing waste, fraud, and abuse-and managing the program more effectively-should be an Administration priority, that alone is not enough to address Medicare's spending problem.

However, critics are correct that a Congressional solution is needed.

We must do everything in our power to safeguard the money in the Trust Fund, until such time as Congress accepts its responsibility to make structural changes to save the program for the millions who depend on it.

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Many of these contractors have valuable experience fighting fraud and efficiently managing health insurance programs. Yet sometimes federal law or administrative barriers prevent us from using their expertise to prevent waste, fraud, and mismanagement in the Medicare program.

Other times, all that is missing is a dose of common sense and leadership.

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In fact, today's hearing is a first step toward a broader long-term effort to build consensus about the best ways to modernize the Medicare program—in its management, operations, and accountability.

And the best way to strengthen Medicare is to help improve and modernize the business model of the agency that oversees the Medicare program: CMS.

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Long term, I hope to work with my colleagues to identify barriers in federal law and within CMS itself that prevent contractors from fighting waste, inefficiency, fraud, and abuse-and I hope we will address them.

I am pleased to have witnesses from both GAO and the HHS OIG with us today to discuss the types and functions of Medicare contractors and how the program can better manage them to meet its goals.

I would note that the HHS OIG is releasing two new reports today on these topics, and I look forward to the testimony of all of our witnesses.

Thank you.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman, for holding today's hearing on the management of Medicare.

For nearly 50 years, Medicare has served as the bedrock program for our Nation's seniors and disabled. What started as a basic benefit covering hospital stays and doctors' visits has continuously evolved and now encompasses comprehensive health care coverage that millions rely on. But in order to build upon the promise of the program, Congress and the Administration must continue to find ways to strengthen the program so it works better for beneficiaries and taxpayers alike.

The Centers For Medicare and Medicaid Services, known as CMS, is tasked with the critical role of administering the program to 50 million beneficiaries. Since Medicare's inception, CMS has enlisted a number of different contractors in different ways throughout the program to help assist in that responsibility. In Parts A and B, they use contractors to help pay the millions of claims from providers as well as enroll providers. In Medicare Advantage, or MA, and the Part D benefit, CMS utilizes the private sector, specifically private insurers, to administer the benefits directly to beneficiaries. In addition, CMS enlists benefit integrity contractors to help further root out waste, fraud, and abuse.

In all these instances, however, CMS is responsible for overseeing all of the contractors' performance and ensuring they bring value and quality to the program. It is also CMS role to conduct regular oversight of plans to ensure that the payments are legitimate and appropriate while simultaneously serving beneficiaries as well.

That is why last summer I introduced the Part D Prescription Drug Integrity Act of 2013, which I believe can help CMS address potential factors contributing to prescription drug abuse. I wrote the bill on the heels of a report by HHS Office of Inspector General, the OIG, which found that Medicare is paying for prescription drugs prescribed by unauthorized individuals.

Given that tens of thousands of these drugs are controlled substances, the study's findings raise questions about patients' safety because of the high potential for abuse and diversion. My bill would require plan sponsors to verify that a prescription for a drug on the controlled substances list was made by an authorized physician before paying for the drug. Under the current law, such a requirement does not exist.

It would also require plan sponsors to have drug utilization programs in place that would restrict access if there was credible evidence of beneficiaries abusing or diverting drugs. In addition, the bill will provide CMS new tools to prevent the payment of claims by fraudulent prescribers or pharmacies.

Now, I think we can all agree that this necessitates constant work. My bill is just one of many ideas to improve Medicare moving forward. The Affordable Care Act made great strides. It expanded benefits to seniors, brought payments to MA closer to traditional Medicare, and rewards plans for quality. It also gave CMS, the OIG and DOJ increased authorities to address fraud, and since

its passage the administration has recovered nearly \$20 billion to taxpayers, a record \$4.2 billion in 2013 alone.

Of course, just this last week this committee heard directly from CMS about the ways in which they hope to continue to strengthen Part D through a number of different policies, so I applaud the Administration for the work they have done to date, and I commend their strong commitment to fighting fraud, waste and abuse in the Medicare program.

The data clearly shows that we are moving in the right direction, but as we will hear today, more can always be done. In fact, the OIG will issue two reports identifying a number of flaws and oversight of MA and Part D plans and the benefits they provide specifically regarding data collection. I look forward to hearing more about these recommendations. In fact, Mr. Waxman and I intend to encourage CMS to quickly adopt these improvements.

So let me thank our witnesses for their participation and work on this topic. The GAO and OIG offer critical insights that informs both CMS and the Congress what will continue to need improvement. Together we must all commit to improving the quality and efficiency of Medicare and be responsible stewards of taxpayer dollars. Robust and aggressive oversight of contractors is critical to this mission.

Thank you, Mr. Chairman. I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

For more than four decades, Medicare has been a critical program for ensuring the health and also the financial well-being of seniors and people with disabilities. The program has evolved significantly over that time, adding benefits, adding coverage options and becoming a major force in the U.S. health care market. As the program has grown and changed, so too has the oversight role of the Centers For Medicare and Medicaid Services, or what we call CMS.

CMS works with private contractors, especially in the original Medicare, the fee-for-service program, to perform the day-to-day program operations such as paying claims, enrolling providers and conducting first level appeals. In Parts C and D of Medicare, CMS contracts with private insurance companies to deliver Medicare's benefits. In either case, CMS is ultimately responsible for making sure that the Medicare Trust Fund dollars paid to these contractors are used appropriately and soundly.

We know from past experience that without strong oversight from CMS, contractors have not always performed adequately and have the potential to abuse the public trust. I am glad we will be hearing from both the Office of Inspector General, OIG, and the Government Accountability Office, GAO today. These two organizations have been critical watchdogs for the Medicare program, alert-

ing us to instances where Medicare's oversight should be strengthened and also areas where Federal intervention is necessary to ensure that taxpayers' dollars are being used appropriately.

A lot has been achieved since passage of the Affordable Care Act to strengthen Medicare. Medicare growth rates have been at an all-time low. This success in reducing the rate of spending growth has been achieved at the same time that benefits have been increased and out-of-pocket costs have been reduced for beneficiaries. And fraud fighting activities have been more successful than ever. Just last week, HHS announced that the HEAT strike forces successfully recovered \$4.3 billion in taxpayer funds, the highest annual amount recovered to date, for a total of \$19.2 billion in recoveries over the last 5 years.

The Administration continues to work to improve the program. The Administration's proposed Part D regulation would make a number of changes to the program to strengthen program management and integrity. Some want to rescind this regulation, but if we are truly serious about program integrity, those proposed program integrity provisions are just the direction CMS should be taking.

Two OIG reports that were released today note significant concern with the reporting of fraud and abuse incidents in the Medicare Advantage and Part D programs. There is wide variability in reporting and many have failed to report any potential fraud and abuse incidents at all. CMS needs to do a better job managing the private insurance companies that participate in Medicare.

But Congress needs to do its part by giving CMS the funds to do its work. We all know that CMS' budget has been inadequate in recent years. For example, while CMS has added nearly 3 million beneficiaries to the Medicare program over the last 2 years, the funding provided by Congress to administer the Medicare program and fight fraud, waste, and abuse has remained essentially flat. Whether we are talking about appropriate funding for nursing home survey and certification, funding for claims, processing and provider education, or funding for implementation of the Affordable CARE Act we should not let our austerity get in the way of proper program management. But I am concerned that is just what is happening. Starving the agency is no more justified than voting to kill Medicare outright by enacting Chairman Ryan's voucher plan.

All things considered, this Administration has done a remarkable job of improving program oversight and management, but we do have more work to do. So I am pleased that we will be hearing about those areas for improvement today.

In closing, I would like to make sure that my message is clear. Is the Medicare program an effective program? Yes. Are there opportunities to improve Medicare management, oversight and overall performance? Of course. And we can do that without harming beneficiaries.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. All members' written statements, opening statements will be made part of the record.

We have one panel before us today. Ms. Kathleen King, Director, Health Care, U.S. Government Accountability Office, is our first witness; Dr. James Cosgrove, Director, Health Care, U.S. Government Accountability Office, is our second witness; and Mr. Robert

Vito, Regional Inspector General for Evaluation and Inspections, Office of Inspector General, U.S. Department of Health and Human Services, is our third witness.

Thank you very much for coming today. Your written testimony will be made part of the record. You will have 5 minutes to summarize your testimony.

At this point the chair recognizes Ms. King for 5 minutes for her opening statement.

STATEMENTS OF KATHLEEN KING, DIRECTOR, HEALTH CARE U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JAMES COSGROVE, DIRECTOR, HEALTH CARE U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND ROBERT VITO, REGIONAL INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF KATHLEEN KING

Ms. KING. Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, my colleague, James Cosgrove and I, are pleased to be here today to discuss the role that contractors and private plans have in the Medicare program.

CMS relies extensively on contractors to assist it in carrying out its responsibilities including program administration, management, oversight and benefit delivery. Contractors have played a vital role in the administration of the program since its enactment in 1965. In fact, Congress designed the original Medicare program so that it would be administered by health insurers or similar organizations experienced in handling hospital and physician claims. Congress also stipulated the process for selecting contractors which differed from the way that most other Federal contractors were awarded in that Medicare contracts were not awarded by a competitive process.

Beginning in the 1980s, the Department of Health and Human Services asked Congress to amend its authority regarding the selection of contractors. It wanted to open the process to a broader set of contractors and increase its ability to reward contractors that were performing well.

In the Medicare Modernization Act of 2003, Congress repealed the statutory limitations on the types of contractors that CMS could use and required compliance with the Federal Acquisition Regulations and competitive procedures to select new contractors. Congress also required CMS to develop performance standards for the new contractors called MACs, or Medicare Administrative Contractors, and gave CMS the authority to provide incentives to the contractors for good performance.

The MACs are responsible for a wide variety of claims administration functions, including processing and paying claims, handling the first level of appeals and conducting medical review of claims. CMS is responsible for overseeing the MACs. Over time, Congress has also authorized the use of other types of contractors in Medicare for program integrity purposes, including investigating potential fraud and recovering overpayments.

Unlike Medicare fee-for-service in which contractors process and pay claims, in Medicare Part C, known as Medicare Advantage, CMS contracts with private organizations to offer health plans that provide all Medicare-covered services except hospice care and may provide other services not available under fee-for-service.

CMS first began contracting with private plans to provide care to enrolled beneficiaries in 1973. Over time, Congress has made various changes in the program, most notably paying plans on a risk basis. As of February 2014, nearly 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage, which is an all-time high. While Medicare contract requirements and program parameters are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with requirements.

While Medicare Part C provides beneficiaries an alternative to obtaining their Medicare benefits through fee-for-service, Congress structured the Medicare Part D program to provide benefits only through private organizations under contract to Medicare. Prescription drug benefits are provided either through Medicare Advantage plans or stand alone private plans. Medicare pay sponsors a monthly amount per capita independent of each beneficiary's drug use.

The Part D program relies on plan sponsors to generate prescription drug savings through negotiating price concessions with entities such as drug manufacturers, pharmacy benefit managers and pharmacies, and managing beneficiary use of drugs. As with Medicare Advantage, while CMS contracts with plan sponsors to provide the Part D benefit, it is responsible for administration of the program, including ensuring that payments made to plans are accurate and that the data plan sponsors submit on price concessions are accurate.

Mr. Chairman, this concludes our prepared remarks. We would be happy to answer questions.

[The prepared statement of Ms. King and James Cosgrove follows:]



United States Government Accountability Office

Testimony

Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

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MEDICARE

Contractors and Private Plans Play a Major Role in Administering Benefits

Statement of Kathleen M. King
Director, Health Care

James Cosgrove
Director, Health Care

GAO Highlights

Highlights of GAO-14-417T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Since the enactment of Medicare in 1965, contractors have played a vital role in the administration of the program. The original FFS program was designed so that the federal government contracted with health insurers or similar private organizations experienced in handling physician and hospital claims to process and pay Medicare claims rather than having the federal government do so. CMS now also contracts with private organizations that provide covered services under the MA program and the Part D prescription drug program.

This statement provides an overview of the manner in which CMS has contracted with private organizations to administer benefits in (1) original FFS Medicare, (2) MA, and (3) the Part D prescription drug program. It is based primarily on products that GAO has issued regarding CMS contracting with claims administration contractors to administer the FFS program, and with other private organizations as part of MA and the Part D prescription drug benefit programs. These products were issued from November 1989 through January 2014 using a variety of methodologies, including reviews of relevant laws, policies, and procedures; data analysis; and interviews with contractors, stakeholders, and CMS officials. We have supplemented information from our prior products with publicly-available data on Medicare private plan contracts and enrollment, CMS-issued guidance for Medicare private plans, and a review of relevant literature. GAO has made numerous recommendations to CMS in these previous products and is not making any new recommendations at this time.

View GAO-14-417T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

March 4, 2014

MEDICARE

Contractors and Private Plans Play a Major Role in Administering Benefits

What GAO Found

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reformed the way the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, contracts with claims administration contractors. From its inception, the process for selecting Medicare fee-for-service (FFS) claims administration contractors was stipulated by Congress and differed from most other federal contracts in that, among other things, the Medicare contracts were not awarded through a competitive process. The MMA repealed limitations on the types of contractors CMS could use and required that CMS use competitive procedures to select new contracting entities to process medical claims and provide incentives for contractors to provide quality services. CMS has implemented the MMA contracting reform requirements by shifting and consolidating all claims administration tasks to new entities called Medicare Administrative Contractors. CMS is currently in the process of further consolidating these contracts. The agency also uses other contractors to review claims to ensure payments are proper and investigate potential fraud.

CMS contracts with private organizations to administer benefits under Medicare Advantage (MA), but has an important administrative and oversight role. MA is the private plan alternative to FFS and differs from FFS in that CMS contracts with private entities, known as Medicare Advantage organizations (MAOs), to provide covered health care services to beneficiaries who enroll. MAOs are paid a predetermined monthly amount for each beneficiary enrolled in one of their health plans and must provide coverage for all FFS services (except hospice care), but may also provide additional coverage. The government first began contracting with private plans in 1973. Several laws since then have changed how the MAOs are paid and the types of plans that can participate. While contract requirements for MAOs and parameters of the program are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with these requirements.

CMS also contracts with private organizations, called plan sponsors, to provide the outpatient prescription drug benefit under Part D. Through the Part D contracts, plan sponsors offer prescription drug plans which may have different beneficiary cost-sharing arrangements (such as copayments and deductibles) and charge different monthly premiums. The Part D program relies on sponsors to generate prescription drug savings through negotiating price concessions with entities such as drug manufacturers, pharmacy benefit managers, and pharmacies, and managing beneficiary use. While CMS contracts with plan sponsors to provide the Part D benefit, the agency has oversight responsibilities. For instance, CMS is responsible for making accurate payments to plan sponsors and ensuring the accuracy of information submitted by plan sponsors to the beneficiary-focused Medicare Plan Finder website. Medicare actuaries have attributed lower-than-projected expenditures in Part D to a combination of factors, including lower-than-projected Part D enrollment, slower growth of drug prices in recent years, greater use of generic drugs, and higher-than-expected rebates from pharmaceutical manufacturers to the prescription drug plans.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

We are pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) contracting in the agency's administration of the Medicare program. Since the enactment of Medicare in 1965, contractors have played a vital role in the administration of the program. In fact, the original Medicare program was designed so that the federal government contracted with health insurers or similar organizations experienced in handling physician and hospital claims to pay Medicare claims. In addition to contracting with organizations to process and pay claims in the original Medicare fee-for-service (FFS) system, CMS also contracts with private organizations to provide covered health services under the Medicare Advantage (MA) program, and outpatient prescription drug coverage under Medicare Part D.¹ With MA and the prescription drug program, private organizations that sponsor health plans are responsible not only for paying claims, but also for ensuring beneficiaries can access their benefits.

In fiscal year 2014 the Medicare program will cover more than 50 million elderly and disabled beneficiaries at an estimated cost of \$595 billion.² In order to administer benefits to Medicare beneficiaries, CMS relies extensively on contractors to assist in carrying out its responsibilities, including program administration, management, oversight, and benefit delivery. In fiscal year 2014, approximately 38 million Medicare beneficiaries will be enrolled in original FFS Medicare and more than 1.2 billion claims will be processed and paid for those beneficiaries by claims administration contractors. In February 2014, Medicare had 571 contracts with MA organizations to provide medical benefits, and offer prescription drug benefits, to over 15.3 million beneficiaries, and an additional 85 contracts with organizations that provide prescription drug benefits outside of the MA program.

¹Medicare consists of four parts. Parts A and B are known as original Medicare or Medicare FFS. Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services. Part C is the private health plan alternative to Medicare FFS and primarily consists of plans that are offered under the MA program. Part D is the outpatient prescription drug benefit, which is provided through private plans.

²Congressional Budget Office, *Medicare—May 2013 Baseline*. (Washington, D.C.: May 14, 2013). This number only includes benefit payments.

This statement provides an overview of the manner in which CMS has contracted with private organizations to administer benefits under (1) original FFS Medicare, (2) Medicare Advantage, and (3) the Part D prescription drug program.³ It is based primarily on previous products that we have issued regarding CMS contracting with claims processors to administer the FFS program, and with other private organizations as part of the MA and Part D prescription drug programs. These products were issued from November 1989 through January 2014 using a variety of methodologies, including reviews of relevant laws, policies, and procedures; data analysis; and interviews with contractors, stakeholders, and CMS officials. We have made numerous recommendations to CMS in these previous products and are not making any new recommendations at this time. We have supplemented information from our prior products with publicly-available data on Medicare private plan contracts and enrollment, CMS-issued guidance for Medicare private plans, and a review of relevant literature. Our work was performed in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**Medicare
Modernization Act
Reformed the Way
CMS Contracts with
Organizations to
Process and Pay FFS
Claims**

From its inception, the process for selecting Medicare claims administration contractors was stipulated by Congress and differed from the process for awarding most other federal contracts in that, among other things, the Medicare contractors were not selected through a competitive process. Before Medicare was enacted in 1965, providers were concerned that the program would give the government too much control over health care. To increase providers' acceptance of Medicare, Congress ensured that health insurers like Blue Cross and Blue Shield would play a key role in administering Medicare, as they already had experience as payers for health care services to physicians and hospitals. Medicare's authorizing legislation required that the claims administration contracts be awarded to carriers and fiscal intermediaries—now referred

³Before July 1, 2001, CMS was known as the Health Care Financing Administration.

to as legacy contractors.⁴ By law, CMS was required to select carriers from among health insurers or similar companies and to choose fiscal intermediaries from organizations that were first nominated by associations representing providers, without the application of competitive procedures. In addition, CMS could not terminate these contracts unless the contractors were first provided with an opportunity for a public hearing, whereas the contractors themselves were permitted to terminate their contracts, unlike other federal contractors. The contractors were paid based on their allowable costs and generally did not have financial incentives that were aligned with quality performance.

Beginning in the 1980s, the Department of Health and Human Services (HHS) asked Congress to amend its authority related to the selection of claims administration contractors, citing several reasons. HHS wanted greater flexibility to administer the program and improve services to beneficiaries and providers. In addition, HHS wanted to promote competition by opening up the contracting process to a broader set of contractors, achieve cost savings, and increase CMS's ability to reward contractors that performed well. Congress included such reform in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).⁵ Specifically, the MMA repealed limitations on the types of contractors CMS could use and required that CMS

- use competitive procedures to select new contracting entities to process medical claims;
- provide incentives for contractors to provide quality services;
- develop performance standards (including standards for customer satisfaction);
- comply with the Federal Acquisition Regulation (FAR), except where inconsistent with provisions of the MMA;⁶
- implement contractor reform by October 2011; and

⁴Carriers handled the majority of Medicare claims for Part B services provided by physicians and other providers, including suppliers of durable medical equipment, while fiscal intermediaries administered claims for Part A and B services provided by hospitals, other institutions, and home health agencies.

⁵Pub. L. No. 108-173, Title II, 117 Stat. 2066, 2167 (2003).

⁶The FAR establishes uniform policies for acquisition of supplies and services by executive agencies. 48 C.F.R. ch. 1.

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- recomplete the contracts at least once every 5 years.⁷

CMS implemented the MMA contracting reform requirements by shifting claims administration tasks from 51 legacy contracts to new entities called Medicare Administrative Contractors (MACs). Originally, CMS selected 15 MACs to process both Part A and B Medicare claims (known as A/B MACs) and 4 MACs to process durable medical equipment (DME) claims (known as DME MACs). CMS also selected 4 A/B MACs to process claims for home health care and hospice services. CMS began awarding the MAC contracts in 2006; however, bid protests and consolidation of some of the MAC jurisdictions delayed some of the MACs from being fully operational. By 2009, most of the legacy contracts had been transitioned to MACs and by December 2013, CMS completed that transition.

Under the FAR, agencies may generally select from two broad categories of contract types: fixed-price and cost-reimbursement. When implementing contractor reform, CMS chose to structure the MAC contracts as cost-plus-award-fee contracts, a type of cost-reimbursement contract. This type of contract allows CMS to provide a financial incentive—known as an award fee—to contractors if they achieve certain performance goals. In addition to reimbursement for allowable costs and a contract base fee (which is fixed at the inception of the contract), a MAC can earn the award fee, which is intended to incentivize superior performance. In 2010, we reviewed three MACs that had undergone award fee plan reviews and found that all three received a portion of the award fee for which they were eligible, but none of the three received the full award fee.⁸

In the new contracting environment, MACs are responsible for a variety of claims administration functions, most of which were previously performed by the legacy contractors. MACs are responsible for processing and paying claims, handling the first level of appeal (often referred to as redeterminations of denied claims), and conducting medical review of

⁷The MMA required that CMS provide for the application of competitive procedures at least every 5 years but also stipulated that contracts could be renewed from term to term without the application of competitive procedures if the contractors met or exceeded performance requirements.

⁸See GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, GAO-10-71 (Washington, D.C.: March 25, 2010).

claims—which is done before or after payment to ensure that the payment is made only for services that meet all Medicare requirements for coverage, coding, and medical necessity.⁹ In addition, the MACs serve as providers' primary contact with Medicare, including enrolling providers, conducting outreach and education, responding to inquiries, and auditing provider cost reports.

CMS is moving toward further consolidation of MAC contracts in hopes that consolidation will further improve CMS's procurement and administration processes. Since the original implementation, CMS chose to consolidate the 15 A/B MACs into 10 jurisdictions and is in the process of that consolidation. Currently, there are 5 consolidated A/B MACs that are fully operational, 7 A/B MACs that will eventually be consolidated into 5 jurisdictions, and 4 DME MACs that are fully operational.

While CMS has relied on contractors to conduct claims administration functions since Medicare's inception and has worked to consolidate these contracts, the agency has been granted additional statutory authority in recent years to award new types of contracts to conduct specialized tasks within the Medicare program. From 1965 to 1996, the legacy contractors were not only responsible for paying claims but also for tasks related to program integrity, such as working with law enforcement on cases of suspected fraud. However, the Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, authorizing CMS to award separate contracts for program integrity activities such as investigating suspected fraud.¹⁰ These contracts are now handled by Zone Program Integrity Contractors and are generally aligned with the same jurisdictions as the MACs. In 2003, the MMA directed CMS to develop a demonstration project testing the use of contractors to conduct recovery audits in Medicare.¹¹ These contractors, known as recovery auditors, conduct data analysis and review claims that have been paid to identify improper payments. While other contractors that review claims are given a set amount of funding to conduct reviews,

⁹Medical review can also be conducted by some other types of CMS contractors. See GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, GAO-13-522 (Washington, D.C.: July 23, 2013).

¹⁰Pub. L. No. 104-191, §§ 201, 202, 110 Stat. 1936, 1992-98 (1996) (codified at 42 U.S.C. §§ 1395j(k)(4), 1395ddd).

¹¹Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256-57 (2003).

recovery auditors are paid contingency fees on claims they have identified as improper. To increase efforts to identify and recoup improper payments, Congress passed the Tax Relief and Health Care Act of 2006, which, among other things, required CMS to implement a permanent and national recovery audit contractor program.¹²

Private Plans Administer Benefits for Beneficiaries Enrolled in Medicare Advantage, But CMS has an Important Administrative and Oversight Role

Unlike Medicare FFS, in which contractors process and pay claims, in Medicare Part C, CMS contracts with private organizations, known as Medicare Advantage organizations (MAOs), to offer MA health plans and provide covered health care services to enrolled beneficiaries. CMS pays MAOs a pre-determined, fixed monthly payment for each Medicare beneficiary enrolled in one of the MAO's health plans. MA plans must provide coverage for all services covered under Medicare FFS, except hospice care, and may also provide additional coverage not available under Medicare FFS.¹³ MA plans, with some exceptions, must generally allow all Medicare beneficiaries who reside within the service area in which the plan is offered to enroll in the plan.¹⁴ In addition, MA plans must meet all federal requirements for participation, including maintaining and monitoring a network of appropriate providers under contract; having benefit cost-sharing amounts that are actuarially equivalent to or lower than Medicare FFS cost-sharing amounts; and developing marketing materials that are consistent with federal guidelines.

Medicare beneficiaries can generally elect to enroll in an MA plan if one is offered in their community.¹⁵ As of February 1, 2014, approximately

¹²Pub. L. No. 109-432, §302, 120 Stat. 2922, 2991-92 (2006) (codified at 42 U.S.C. § 1395ddd(h)).

¹³Most MA plans also provide prescription drug coverage.

¹⁴Exceptions include special needs plans (SNP) and employer group plans. SNPs offer benefit packages tailored to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions. Employer group plans can be offered to employers' or unions' Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans.

¹⁵Medicare beneficiaries with end-stage renal disease (ESRD) may only enroll in an MA plan if they meet certain criteria. For example, beneficiaries with ESRD may enroll in an MA plan if (1) they were already enrolled in the MA plan when they developed ESRD; (2) they are eligible for a plan offered by their current or former employer or union that has opted to enroll beneficiaries with ESRD; or (3) they had a successful kidney transplant.

15.3 million beneficiaries—nearly thirty percent of all Medicare beneficiaries—were enrolled in MA plans—an all-time high. Those plans were offered through 571 contracts between MAOs and CMS.¹⁶

Substantial changes in the law regarding contract requirements and other parameters of the program—including payment rates—have contributed to fluctuations in the number of contracts and enrolled beneficiaries over the years. Under authority provided by the Social Security Amendments of 1972, CMS first began contracting with private plans to provide care to enrolled beneficiaries in 1973.¹⁷ The law required plans to provide benefits covered under Medicare FFS and to meet certain other standards. Plans were generally paid on the basis of their costs during these early years of contracting. By 1979, the government had 33 contracts with organizations offering private plans.

A decade after the Social Security Amendments of 1972, the Tax Equity and Fiscal Responsibility Act of 1982 authorized the first full-risk plans that were paid a fixed monthly amount per beneficiary that was set at 95 percent of the expected spending for beneficiaries in Medicare FFS.¹⁸ The payment for each beneficiary was adjusted by demographic and other factors. The accuracy of this adjustment was criticized by us and other researchers. The demographic payment adjusters resulted in excess payments to those plans that enrolled healthier beneficiaries with below-average health care costs. This, in part, encouraged continued growth in Medicare private plans and by May 1, 1997, 4.6 million beneficiaries—nearly 12 percent of all Medicare beneficiaries—were enrolled in private plans under 280 contracts. At the same time, concerns were raised that basing plan payment rates on local Medicare FFS spending—the methodology used to geographically adjust payment rates—resulted in no or low plan participation in some areas, particularly rural areas.

¹⁶An MAO may have multiple contracts—for example, covering different geographic areas or offering different types of plans—and each contract may include multiple health plan benefit packages.

¹⁷Pub. L. No. 92-603, § 226, 86 Stat. 1329, 1396 (1972).

¹⁸Pub. L. No. 97-248, § 114, 96 Stat. 324, 341 (1982).

The Balanced Budget Act of 1997 (BBA) formally established private plans as Part C of Medicare and introduced additional changes to the program.¹⁹ These changes to the program included new types of plans that could be offered,²⁰ the standards applied to the contracts, beneficiary enrollment rules, and payment rules. In an effort to refine the payment methodology, the BBA required CMS to use health status measures to adjust payments to plans,²¹ added a payment methodology establishing a minimum amount or floor rate, and limited rate updates in higher payment counties that, with other refinements, resulted in reducing some of the payment differences between high and low spending areas. Following these changes, and coincidental with broad-based dissatisfaction with managed care practices more generally, organizations offering Medicare private plans reversed what had been a rapid expansion in the mid-1990s and began a period of plan withdrawals and declining beneficiary enrollment in plans. For example, from 1999 through 2003, the number of Medicare contracts with private plans fell from 309 to 154. During the same period, private plan enrollment fell from about 6.3 million to 4.6 million beneficiaries. Subsequent legislation providing new methods of adjusting payments to account for health status, among other things, did little to entice them back into the program.²²

Private plan participation in Medicare began to rebound after passage of the MMA. The law made the program more attractive to plans by establishing minimum payments of 100 percent of Medicare FFS spending and pegging the minimum increase to the Medicare national per capita growth rate, providing substantial annual increases over those authorized under the BBA. As of December 2009, enrollment had grown to about 10.9 million beneficiaries.

¹⁹See Pub. L. No. 105-33, § 4001, 111 Stat. 251, 274 (1997).

²⁰For example, CMS was authorized to contract with Preferred Provider Organizations (PPO). Beneficiaries in PPOs can see both in-network and out-of-network providers but must pay higher cost-sharing amounts if they use out-of-network services.

²¹The BBA uses the term "risk adjustment factors."

²²See the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, Title V, §§ 501 et seq., 113 Stat. 1501, 1501A-378 (1999) and the Medicare, Medicaid and SCHIP Improvement Act of 2000, Pub. L. No. 106-554, App. F, Title VI, Subtitle A, §§ 601 et seq., 114 Stat. 2763, 2763A-554 (2000).

The Patient Protection and Affordable Care Act (PPACA) included several changes to the MA program, such as bringing payments to plans closer to Medicare FFS, and rewarding plans for quality.²³ Since March 2010, enrollment in MA plans has grown from 11.0 million to 15.3 million—an increase of about 39 percent. While contract requirements for MAOs and parameters of the program are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with these requirements. The agency's responsibilities include, among other things, making monthly payments to MA plans, implementing health status adjustments to the payments, establishing processes for enrolling and disenrolling beneficiaries, reviewing marketing materials, providing for independent review of coverage appeals, conducting audits, and enforcing compliance. The audits typically involve a combination of desk reviews of documents submitted by MA plans, and at CMS's discretion, site visits. To ensure compliance, CMS may take a variety of enforcement actions, ranging from informal contacts offering technical assistance to civil money penalties or plan suspension for egregious or sustained noncompliance.

Private Plans Also Administer Prescription Drug Coverage Under Part D

Whereas MA offers beneficiaries an alternative way to access their Part A and B benefits, Part D is structured to provide benefits only through private organizations under contract to Medicare.²⁴ Under the Part D program, which began providing benefits on January 1, 2006, CMS contracts with private organizations called plan sponsors.²⁵ Part D plan sponsors offer outpatient prescription drug coverage either through stand-alone prescription drug plans for those in original FFS Medicare, or through MA prescription drug plans for beneficiaries enrolled in MA. Through the Part D contracts, plan sponsors offer prescription drug plans

²³See Pub. L. No. 111-148, Title III, Part III, Subtitle C, §§ 3201 et seq., 124 Stat. 119, 442 (2010). For purposes of this testimony, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (2010).

²⁴In some cases beneficiaries can enroll in a prescription drug plan that is offered by an employer or union. Those plans also contract with CMS.

²⁵Plan sponsors include health insurance companies and pharmacy benefit managers. Although pharmacy benefit managers typically manage prescription drug benefits for third-party payers, some pharmacy benefit managers have contracted directly with Medicare to offer Part D plans.

which may have different beneficiary cost-sharing arrangements (such as copayments and deductibles) and charge different monthly premiums.

Medicare pays plan sponsors a monthly amount per enrollee independent of each enrollee's drug use, therefore creating an incentive for the plan sponsor to manage spending. Payments to prescription drug plan sponsors are adjusted according to the risk factors—including diagnoses and demographic factors—of beneficiaries enrolled in a sponsor's plans. However, sponsors still have an incentive to control spending to ensure it remains below the adjusted monthly payments received from CMS and payments received from enrolled beneficiaries. Sponsors can lower drug spending by applying various utilization management restrictions to drugs on their formularies.²⁶ The Part D program also relies on sponsors to generate prescription drug savings, in part, through their ability to negotiate price concessions, such as rebates and discounts, with entities such as drug manufacturers, pharmacy benefit managers, and pharmacies.

The MMA required that plan sponsors offer beneficiaries a standard benefit plan, with specified deductible and coinsurance amounts, or a plan with benefits that are actuarially equivalent to the standard plan. Actuarially equivalent plans have the same average benefit value as the standard benefit plan but a different benefit structure. If a sponsor offers the standard benefit or an actuarially equivalent plan, it may also offer an enhanced plan with a higher average benefit level in the same area. For instance, an enhanced plan may offer lower cost sharing, an expanded formulary, or coverage in the coverage gap.²⁷ According to the Medicare Payment Advisory Commission, about 94 percent of enrollees in stand-

²⁶ A formulary is a list of the prescription drugs that a plan covers and the terms under which they are covered.

²⁷ Prior to 2011, enrollees exceeding an initial coverage limit were responsible for paying the full cost of covered drugs until they reached an out-of-pocket maximum. Beginning in 2011, PPACA established the Medicare Coverage Gap Discount Program to assist beneficiaries who do not receive Part D's low-income subsidy with their drug costs when they reach the coverage gap. See GAO, *Medicare Part D Coverage Gap: Discount Program Effects and Brand-Name Price Trends*, GAO-12-914 (Washington, D.C.: Sept. 28, 2012).

alone prescription drug plans in 2012 were enrolled in actuarially equivalent or enhanced benefit plans.²⁸

While CMS contracts with plan sponsors to offer the Part D benefit, the agency has an oversight role. As with MA, CMS is responsible for ensuring that the payments it makes to plan sponsors are accurate. Given that final payments to plan sponsors are based, in part, on the price concessions that plan sponsors have negotiated, CMS is responsible for ensuring that data plan sponsors submit on price concessions are accurate.²⁹ CMS also ensures that plan sponsors submit accurate information to the Medicare Plan Finder interactive website,³⁰ which helps beneficiaries compare different plans and identify the plan that best meets their needs.³¹ CMS oversees the complaints and grievances processes and may rely on complaints and grievances data to undertake compliance actions against specific plan sponsors.³² CMS also oversees Part D sponsors' fraud and abuse programs, which include compliance plans that must include measures to detect, correct, and prevent fraud, waste, and abuse.³³

Medicare spending on the Part D program has been lower than originally anticipated. Medicare's actuaries have attributed lower-than-projected expenditures to a combination of factors, including lower-than-projected Part D enrollment, slower growth of drug prices in recent years, greater

²⁸Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, (Washington, D.C.: March 2013).

²⁹See GAO, Medicare Part D Prescription Drug Coverage: Federal Oversight of Reported Price Concessions Data, GAO-08-1074R, (Washington, D.C.: Sept. 30, 2008).

³⁰See www.medicare.gov/find-a-plan.

³¹See GAO, *Medicare Part D: CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability*, GAO-14-143, (Washington, D.C.: Jan. 10, 2014).

³²If beneficiaries are not satisfied with certain aspects of the Part D program, they may file a complaint with CMS, a grievance with their plan sponsor, or both. See GAO, *Medicare Part D: Complaint Rates Are Declining, but Operational and Oversight Challenges Remain*, GAO-08-719, (Washington, D.C.: June 27, 2008).

³³42 C.F.R. § 423.504(b)(4)(vi) (2013). See GAO, *Medicare Part D: CMS Conducted Fraud and Abuse Compliance Plan Audits, but All Audit Findings Are Not Yet Available*, GAO-11-269R, (Washington, D.C.: Feb. 18, 2011).

use of generic drugs, and higher-than-expected rebates from pharmaceutical manufacturers to the prescription drug plans.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, this completes our prepared statement. We would be pleased to respond to any questions that you may have at this time.

**GAO Contacts and
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Acknowledgments**

If you have any questions about matters discussed in this testimony, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other key contributors to this report include Lori Achman, Sheila K. Avruch, George Bogart, Christine Brudevold, Christine Davis, Christie Enders, and Gregory Giusto.

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Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Cosgrove for 5 minutes for an opening statement.

STATEMENT OF JAMES COSGROVE

Dr. COSGROVE. Chairman Pitts, thank you very much. Ms. King has submitted a joint statement for both of us covering GAO and as such I don't have a separate oral statement.

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Vito for 5 minutes for his opening statement.

STATEMENT OF ROBERT VITO

Mr. VITO. Good morning, Mr. Chairman and members of the subcommittee. I am Robert Vito, Regional Inspector General for the Office of Evaluation and Inspections at the U.S. Department of Health and Human Services Office of Inspector General. Thank you for the opportunity to testify about CMS oversight of Medicare contractors.

Two years ago, I testified before you about reoccurring problems that we had identified with CMS oversight of benefit integrity contractors. CMS relies on contractors to administer half a trillion dollars in Medicare spending every year. OIG understands that effective oversight of Medicare contractors is a continuous, demanding and often resource-intensive process for CMS. Unfortunately, some of the same problems we identified in the past with CMS's oversight of benefit integrity contractors also extends to other CMS contractors.

Today the OIG is releasing two reports that highlight similar oversight problems with Medicare Advantage and Part D contractors. The OIG has found that CMS does not leverage data to improve oversight, does not investigate variation in data across contractors, does not address underperforming contractors timely and require corrective action plans, and does not share information with beneficiaries and other stakeholders that could assist anti-fraud efforts.

Since 2008, we have repeatedly recommended that CMS require Part D plans to report fraud and abuse data. Rather, CMS merely encourages Part D plans to voluntarily report these data. Under this voluntary reporting system, less than half of the Part D plans have reported data and the reported data have varied significantly across plans.

Due to CMS failure to investigate variation among Part D plans, we do not know if the plans are reporting incorrect data, have ineffective programs to detect fraud and abuse, or lack a common understanding of what constitutes a potential fraud and abuse incident. Further, without detailed information on fraud and abuse incidents, CMS is missing the opportunity to discover and alert plans and law enforcement to emerging fraud and abuse schemes.

CMS has also made limited use of Part C data to oversee Medicare Advantage plans despite investments in contractors' review of the data. The Part C reporting requirement data are a significant resource for oversight and improvement of the Medicare Advantage Program.

CMS has implemented regular and intensive reviews of the Part C data through its contractor, but conducted minimal follow-up on the data issues that it identified. For example, CMS has not determined whether outlier data reflected inaccurate reporting or atypical plan performance. CMS also has not used its contractor data reports and analysis to inform the selection of MA plans for audits or to issue compliance notices for performance concerns. This would be like taking your car to a mechanic, having them run diagnostic tests, and then not using the tests to determine if your car is running well and safe to drive.

Our review of the Medicare administrative contractors found that CMS performance reviews of MACs were extensive but were not always timely, and even when CMS identified quality assurance standards that were not met, CMS did not always resolve the problem. There were two MACs that consistently underperformed, but these MACs had their contract option years renewed.

Lastly, CMS is missing a critical opportunity to enlist millions of Medicare beneficiaries in the fight against fraud. MACs mail Medicare summary notices, or MSNs, to beneficiaries to show them what Medicare claims have been paid on their behalf. These notices can serve as a key fraud and detection tool when beneficiaries identify and report suspicious information contained on their MSNs. However, the OIG found that over 4 million notices were not delivered to the beneficiary.

Further, CMS has not instructed MACs on whether or how to track or follow up on undelivered MSNs. It is critical that MSNs be timely and appropriately delivered to beneficiaries. If just one beneficiary sees something suspicious on their notice and reports it to Medicare, it may lead to a fraud case that saves millions of dollars.

In conclusion, the OIG recognizes the challenging job CMS faces in the oversight of its contractors. OIG has recommended actions that CMS can undertake, and now CMS is considering some of these recommendations.

Thank you again for your interest in this important area and for the opportunity to testify before this subcommittee today.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Vito follows:]

Testimony of:
 Robert A. Vito
 Regional Inspector General for Evaluation and Inspections
 Office of Inspector General
 U.S. Department of Health and Human Services

Good morning Chairman Pitts, Ranking Member Pallone, and other distinguished Members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections at the U.S. Department of Health and Human Services, Office of Inspector General (OIG). Thank you for the opportunity to testify about the Centers for Medicare & Medicaid Services' (CMS) oversight of Medicare contractors.

CMS relies on contractors to administer the Medicare program and is responsible for overseeing the contractors' performance. CMS contracts with Medicare Administrative Contractors (MACs) to process Parts A and B claims; Medicare Advantage (MA) plans to provide managed care services under Part C; Part D plans to provide prescription drug coverage under Part D; and benefit integrity contractors, which serve to protect Medicare from fraud, waste, and abuse.

RECURRING ISSUES LIMIT CMS'S OVERSIGHT OF MEDICARE CONTRACTORS

Two years ago, OIG testified before this Committee and outlined problems with CMS's oversight of its benefit integrity contractors' activities.¹ These problems included CMS's limited use of contractor-reported program activity data for oversight activities, significant variation in results across contractors, and a lack of uniformity and understanding of key fraud terms and definitions across contractors.

My testimony today is based on recent evaluation reports, as well as a larger body of OIG work identifying vulnerabilities in CMS's oversight of contractors. Today, OIG is issuing two reports on CMS's oversight of its Medicare Parts C and D contractors that highlight problems similar to those that we identified with its benefit integrity contractors.² Earlier this year, OIG issued two reports on MACs' activities that also highlight the need for more timely and targeted oversight of the contractors administering Medicare Parts A and B.³

¹ Testimony of Robert A. Vito, Regional Inspector General for Evaluation and Inspections, before the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce on Medicare Contractors' Efforts to Fight Fraud - Moving Beyond "Pay and Chase." Available at http://oig.hhs.gov/testimony/docs/2012/Vito_testimony_06082012.pdf.

² OIG, *CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited* (OEI-03-11-00720), March 2014, and *Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse* (OEI-03-13-00030), March 2014.

³ OIG, *Medicare Administrative Contractors' Performance* (OEI-03-11-00740), January 2014, available at <http://oig.hhs.gov/oei/reports/oei-03-11-00740.pdf>, and *Over Four Million Medicare Summary Notices Mailed to Beneficiaries Were Not Delivered in 2012* (OEI-03-12-00600), January 2014, available at <http://oig.hhs.gov/oei/reports/oei-03-12-00600.pdf>.

Regardless of the type of Medicare contractor—Parts A and B fee-for-service, MA, or Part D—there are common issues that limit CMS’s oversight of its contractors. CMS has not:

- leveraged contractor-reported data to improve oversight;
- investigated variation in data across contractors to determine underlying causes, especially when it is not explained by the size or geographical jurisdiction of contractors;
- addressed underperforming contractors timely and required corrective actions for all performance standards that were not met; or
- shared information with beneficiaries and other stakeholders that could assist antifraud efforts.

CMS HAS NOT LEVERAGED CONTRACTOR-REPORTED DATA TO IMPROVE ITS OVERSIGHT OF MA AND PART D PLANS

With more than \$200 billion in expenditures and millions of Medicare beneficiaries covered under MA and Part D, it is paramount that CMS perform regular and rigorous oversight of its MA and Part D plans. This oversight ensures that beneficiaries are served well by the plans and that payments made on behalf of the programs are legitimate and appropriate. However, the two reports released today demonstrate that CMS has not fully leveraged contractor-reported data to improve its monitoring and oversight of MA and Part D plans. CMS also has not investigated extreme variations in contractor-reported MA and Part D data to determine the underlying causes.

CMS has made limited use of Part C data to oversee MA plans despite investments in contractor reviews of the data

CMS has collected data from MA plans under the Part C Reporting Requirements since 2009. These reporting requirements include data on serious reportable adverse events, grievances, and appeals. The Part C Reporting Requirements data are a significant resource for oversight and improvement of the MA program because they pertain to the performance of MA plans and often are not available to CMS from other sources.

In its report released today, OIG found that, while CMS’s contractor had performed regular and extensive analytics to identify inaccuracies and outliers in the Part C data, CMS did not use the data to inform its oversight of the MA plans.

CMS’s contractor identified issues with the Part C data reported by MA plans. CMS contracted with Acumen to review and analyze all Part C Reporting Requirements data submitted by MA plans, identify data issues, and notify affected MA plans. We found that Acumen has performed the required reviews and supplied both CMS and MA plans with information about the data issues it identified. For 2010 and 2011, Acumen identified 2,134 data issues across 513 of the 638 MA plans that submitted data. Specifically, the data issues included 1,904 outlier incidents, 147 incidents of overdue data, 50 incidents of inconsistent data, and

33 incidents of placeholder data.⁴ These data issues could signal performance problems that CMS could target for review.

CMS did not follow up with MA plans about data issues and did not use reported data to oversee MA plan performance. Acumen provided CMS with information about each data issue it identified before notifying the MA plans on CMS's behalf. Many MA plans received notices about submissions of outlier data, but CMS did not determine whether these outliers reflected inaccurate reporting or atypical plan performance. CMS did not contact any MA plans to determine the cause of the outlier data values, ensure that inconsistent data were corrected, or address data submitted with placeholder values.

Part C regulations authorize CMS to find an MA plan out of compliance with contract requirements when the plan's performance represents an outlier relative to the performance of peer organizations. However, CMS has not used analytics and data reports provided by Acumen to inform the selection of MA plans for audits or to issue compliance notices to MA plans for performance concerns.

CMS has not shared the Part C Reporting Requirements data with the public. As far back as 2009, CMS indicated that one purpose of Acumen's contract was to create Public Use Files. To date, CMS has not released any Public Use Files regarding the Part C Reporting Requirements data. Additionally, CMS has not included any of the Part C Reporting Requirements measures in its calculation of the star ratings for MA plans. These ratings are posted for consumers on the Medicare Plan Finder Web site and are used to award value-based bonus payments to MA plans.

CMS has not required mandatory reporting of fraud and abuse data by Part D plans nor has it taken advantage of the voluntarily reported data to monitor plans

MA and Part D plans' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the Parts C and D programs. Since 2008, OIG has repeatedly recommended that CMS require mandatory reporting of fraud and abuse data by MA and Part D plans. CMS has disagreed and, therefore, does not require mandatory reporting of fraud and abuse by these plans. Instead, since 2010, it has encouraged Part D plans to voluntarily report fraud and abuse.

OIG is releasing a report today that determines the extent to which Part D plans voluntarily reported fraud and abuse data and determines whether CMS used these data to monitor and oversee plans' activities to identify fraud and abuse. We found that CMS has not used the data to monitor the success of its Part D plans' fraud and abuse identification activities.

⁴ An MA plan is considered to have submitted Part C data that contain placeholders if it submitted values of zero for two or more measures in a reporting period. An MA plan submitted inconsistent data if it submitted data values for a measure that contradict one another. An outlier data value is a data value that falls outside a specified range of reported values, or falls above or below a predetermined benchmark value.

More than half of Part D plans did not voluntarily report fraud and abuse data. Between 2010 and 2012, no more than 40 percent of Part D plans reported any fraud and abuse data to CMS. The percentage reporting declined each year—40 percent of plans reported data in 2010, 37 percent in 2011, and 35 percent in 2012. The sponsors that did not voluntarily report any data for all 3 years covered 14.5 million beneficiaries in 2012, or 46 percent of the total number of beneficiaries enrolled in Part D plans. Therefore, CMS does not have data on incidents of potential fraud and abuse for plans covering almost half of the beneficiaries enrolled in Part D. While CMS has instituted voluntary rather than mandatory reporting, it has stated that it is difficult to draw conclusions from the data that can be shared among plans and law enforcement because the reporting of the data is voluntary.

Identification of fraud and abuse varied significantly across Part D plans, and important details about fraud abuse are not collected. Overall, plans identified 64,135 incidents of potential fraud and abuse between 2010 and 2012. The number of such incidents identified varied significantly among the 320 plans that voluntarily reported data. More than one-third did not identify any incidents of potential fraud and abuse in at least one year. In contrast, in 2012, just three Part D plans identified more than two-thirds of all reported fraud and abuse incidents that year. The number of incidents that plans identified annually ranged from 0 to 13,919, with a median of 4 incidents per plan.

The variability in the number of incidents identified was often not explained by the size of the plans' enrollment. However, CMS did not perform any work to determine the underlying cause of the variability. Without conducting this analysis, CMS cannot determine whether plans are reporting incorrect data, have ineffective programs to detect fraud, or lack a common understanding of what constitutes a potential fraud and abuse incident.

Moreover, CMS does not collect detailed information on the incidents, such as who committed the potential fraud, and other case-specific details that could assist in followup. Without this detailed information, CMS may be missing the opportunity to discover and alert plans to new or expanding fraud and abuse schemes.

More than a quarter of Part D plans reported initiating no inquiries and corrective actions regarding incidents of potential fraud and abuse. CMS requires plans to conduct a timely, reasonable inquiry and to carry out appropriate corrective actions in response to potential fraud and abuse. From 2010 to 2012, 28 percent of plans that identified fraud reported initiating no inquiries and corrective actions with regard to any of the incidents. In that timeframe, these 74 plans identified 4,028 incidents of potential fraud and abuse. Though they are not required to do so, Part D plans can also refer incidents of potential fraud and abuse to CMS, Federal and local law enforcement, and State agencies. Sixty-one percent of the plans did not refer any identified incidents to these entities.

CMS did not use the reported data to monitor Part D plans' fraud detection and prevention efforts. CMS reported that it did not use the voluntarily reported data for monitoring or oversight purposes. CMS did not follow up with plans about their fraud and abuse control

activities related to the voluntarily reported data. More than 2 years after receiving the data, CMS has not used the data to assess plans' fraud prevention and detection efforts. However, CMS stated that it is formulating processes to follow up with Part D plans and to use the reported data to monitor and oversee them.

Additionally, CMS reported that it did not share the data on potential fraud and abuse with plans or law enforcement but did begin sharing the data with its Medicare Drug Integrity Contractor (MEDIC) in 2013.⁵ According to CMS, the MEDIC has developed methodologies to analyze the data. CMS stated that it is discussing and formulating processes for sharing data with plans and law enforcement.

MACS DID NOT MEET ALL PERFORMANCE STANDARDS, TWO MACS CONSISTENTLY UNDERPERFORMED, AND CMS REVIEWS OF MAC PERFORMANCE WERE NOT ALWAYS CONDUCTED TIMELY

MACs process hundreds of billions of dollars in Parts A and B fee-for-service claims every year. CMS awarded \$4.3 billion over a 5-year period to the 16 MACs that were operational in 2013. Given the billions of dollars awarded to MACs and the critical role they play in administering Medicare Parts A and B, effective oversight of MACs' performance is important to ensure that they are adequately processing claims and performing other assigned tasks. In January 2014, OIG issued a report that describes the extent to which MACs met performance standards and CMS assessed and monitored MACs' performance.

CMS's performance reviews of MACs were extensive, but they were not always completed timely

Overall, CMS conducted extensive activities to review MACs' performance. This is important because MAC reviews provide vital performance information and can be used by CMS to support future award decisions. However, for the same reasons, it is also important that CMS complete these reviews timely. While CMS goes through an extensive process to finalize MACs' performance evaluations, it did not always do so timely. For the 25 evaluations that had a final report date in the performance reporting system, the time between the end of the performance period and the date the report was finalized ranged from 8 months to more than 2 years. If performance evaluations are not completed timely, the information they contain cannot be used to support future contract award decisions.

⁵ The MEDIC is responsible for detecting and preventing fraud, waste, and abuse in Medicare Parts C and D nationwide.

MACs met the majority of quality assurance standards reviewed by CMS; however, a quarter of unmet standards were not resolved

There were 1,201 standards included in CMS's quality assurance reviews of MACs across 2 performance periods. Overall, MACs met 74 percent (891) of these standards and did not meet 26 percent (310). CMS conducts quality assurance reviews to ensure that MACs are providing the quality of services required in their contracts. MACs did not meet over 40 percent of standards in each of three areas—processing of provider enrollment applications, processing of claims in which Medicare is not the primary payer, and managing the timeliness and accuracy of the Medicare appeals process. MACs had not resolved issues with 27 percent of unmet standards and CMS did not require action plans for 12 percent of unmet standards. OIG found that unmet standards without action plans were almost four times more likely to have issues go unresolved.

Two MACs consistently underperformed across various CMS reviews

Two MACs did not meet a high percentage of quality assurance standards. One of the MACs had the highest percentage of unmet standards (48 percent), and over half of the issues identified through its reviews had not been resolved. The second MAC did not meet 31 percent of the quality assurance standards.

CMS award fee distributions also indicated underperformance by these two MACs relative to the others. MAC contracts include an award fee that a MAC may earn if its performance exceeds basic requirements. There was an overall award fee pool of \$39 million, of which MACs earned two-thirds, or \$26 million. CMS awarded the lowest percentage of award fees to the two underperforming MACs—35 and 40 percent of their respective award fee pools. The two MACs were the only MACs that did not earn any award fee for the contract administration metric during one performance period. This metric evaluates a MAC's overall ability to manage its contract, specifically in areas such as communication, flexibility, staffing, and cost management.

Despite performance issues, CMS renewed all of the contract option years for these two MACs. However, when the contract for one MAC's jurisdiction was recompeted, CMS awarded the contract to a different contractor. At the end of 2013, the second MAC's contract was still in effect and the recompet for the jurisdiction had not yet been completed. According to CMS staff, the agency has considered not renewing contract option years for MACs performing at substandard levels. However, it takes approximately one year for CMS to solicit and award a new contract. With only 4 option years for each contract, CMS reported that the resources and risk involved in conducting an unforeseen procurement to replace a poorly performing MAC made such a decision impractical.

CMS IS MISSING THE OPPORTUNITY TO ENLIST MILLIONS OF MEDICARE BENEFICIARIES IN THE FIGHT AGAINST FRAUD THROUGH LACK OF GUIDANCE TO MACS ON UNDELIVERED MEDICARE SUMMARY NOTICES

As part of its efforts to reduce Medicare fraud and abuse, CMS relies on beneficiaries to report suspicious activity identified on their Medicare Summary Notices (MSNs). MSNs are paper forms that summarize Parts A and B processed claims. MACs are responsible for processing MSNs and mailing them to beneficiaries. A CMS official stated in June 2013 that beneficiaries' best defense against fraud includes checking their MSNs for accuracy. If MSNs go undelivered, beneficiaries do not have the opportunity to review the services or items billed to Medicare.

In January 2014, OIG released a report that provided information on the quantity of undelivered MSNs and the procedures that MACs⁶ use to track and follow up on undelivered MSNs.

Over 4 million MSNs were not delivered to beneficiaries in 2012

OIG found that CMS did not monitor how many MSNs failed to reach Medicare beneficiaries during 2012. In 2012, MACs mailed 194 million MSNs to beneficiaries. According to the MACs, approximately 4.2 million MSNs were returned as undeliverable in 2012. MACs could not provide the total Medicare payment amounts associated with these undelivered MSNs. However, the allowed amounts associated with a sample of 1,445 undelivered MSNs returned in January 2013 totaled \$2.7 million. Of 1,445 undelivered MSNs, 51 included paid claims that were associated with beneficiary or provider numbers that had been compromised in some way, e.g., identity theft.

Tracking and followup on undelivered MSNs is limited and varies across contractors

CMS requires MACs to provide MSNs to Medicare beneficiaries, but it has not issued guidance regarding whether or how to track and follow up on undelivered MSNs. In practice, not all MACs track or follow up on undelivered MSNs, and those that do utilize a variety of methods. Half of MACs attempt to verify addresses on undelivered MSNs, but few conduct any further followup.

MACs reported that incorrect or invalid addresses were the most common reasons MSNs were undeliverable. Eight years ago, CMS had recognized that beneficiary address data were not transferring correctly from its system to its contractors' shared systems. CMS instructed system maintainers to modify the system to accept the complete addresses. From a sample of undelivered MSNs, OIG identified incomplete addresses that appeared to result from incorrect transfers of address data into MACs' shared systems.

⁶ There were 17 MACs, 1 fiscal intermediary, and 1 carrier processing MSNs during OIG's review.

Because of the large number of MSNs that fail to reach beneficiaries and the lack of CMS guidance to MACs on how to address the underlying cause of this failure, CMS is missing the opportunity to solicit beneficiaries' assistance in its fraud detection efforts.

ACTIONS TO IMPROVE CMS'S OVERSIGHT OF MEDICARE CONTRACTORS

The effective oversight of Medicare contractors is a continuous, demanding, and often resource-intensive process. However, OIG has discovered a number of recurring issues that limit CMS's oversight across all contractor types. For MA and Part D plans, CMS has taken steps to collect potentially useful data, but has not followed up to determine the causes of outlier or questionable data. These data could assist CMS in uncovering potential performance issues with its contractors. CMS has developed a multitude of methods to review MAC performance and identify performance issues, but does not always have the tools in place to ensure that issues are corrected. There are a number of actions that CMS should take to improve its oversight of Medicare contractors. CMS has stated that it is considering implementing some of these actions. For example, after many years of not concurring with OIG recommendations to analyze variation in contractor-reported data, CMS has recently agreed to begin reviewing the variations among MA and Part D plans' data.

To ensure that CMS has accurate and complete data for its oversight, CMS should:

- Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to incidents of potential fraud and abuse.
- Provide MA and Part D plans with specific guidelines on how to define and count incidents of potential fraud and abuse, related inquiries, and corrective actions.

To address significant variation in contractor performance, CMS should:

- Determine whether outlier data values submitted by MA plans for the Part C Reporting Requirements reflect inaccurate reporting or atypical performance.
- Review data from plans to determine why certain plans reported especially high or low numbers of incidents of potential fraud and abuse, related inquiries, and corrective actions.

To monitor, improve, and address poor contractor performance, CMS should:

- Use appropriate Part C Reporting Requirements data as part of its reviews of MA plans' performance.
- Seek legislative change to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS performance requirements.
- Require action plans for all unmet quality assurance standards for MACs.
- Use results of MAC quality assurance reviews to help select award fee metrics.
- Establish and meet reasonable timeframes for issuing MAC performance reports.

To increase the sharing of information with beneficiaries and other stakeholders that would lead to improved awareness of the quality and integrity of Medicare services, CMS should:

- Provide guidance to MACs about the handling and review of MSNs that are returned as undeliverable.
- Ensure that the beneficiary address information used by MACs to print addresses on MSNs is complete and properly formatted.
- Establish a timeline for releasing the Part C Reporting Requirements Public Use Files.
- Share plans' reported data on potential fraud and abuse with all plans and law enforcement.

OIG WILL CONTINUE TO REVIEW THE OVERSIGHT OF CMS CONTRACTORS

CMS contractors are responsible for administering more than a half a trillion dollars in Medicare benefits each year. Because of the importance of contractors in ensuring the effectiveness of CMS programs and OIG's mission to protect the integrity of the Medicare program and the health and welfare of the beneficiaries it serves, OIG will continue to broaden its body of work on contractor oversight. OIG has work underway to review the landscape of contracts awarded at CMS with an emphasis on CMS's contract closeout procedures. OIG is continuing to review performance across all types of Medicare benefit integrity contractors. OIG also is engaged in reviewing CMS's contracting for the new health insurance marketplaces under the Affordable Care Act, including the awarding and oversight of, as well as contractor performance under, those contracts.

Thank you for your support of OIG's mission and the opportunity to testify about CMS oversight of contractor activities.

RECURRING ISSUES LIMIT CMS'S OVERSIGHT OF MEDICARE CONTRACTORS

CMS has not:

- leveraged contractor-reported data to improve oversight,
- investigated variation in data across contractors to determine underlying causes,
- addressed underperforming contractors timely and required corrective actions for all performance standards that were not met, or
- shared information that could assist contractors' antifraud activities.

CMS HAS MADE LIMITED USE OF PART C DATA TO OVERSEE MA PLANS DESPITE INVESTMENTS IN CONTRACTOR REVIEWS OF THE DATA

- CMS's contractor identified issues with the Part C data reported by MA plans.
- CMS did not follow up with MA plans about data issues and did not use reported data to oversee MA plan performance.
- CMS has not shared the Part C Reporting Requirements data with the public.

CMS HAS NOT REQUIRED MANDATORY REPORTING OF FRAUD AND ABUSE DATA BY PART D PLANS NOR HAS IT TAKEN ADVANTAGE OF THE VOLUNTARILY-REPORTED DATA TO MONITOR PLANS

- More than half of Part D plans did not voluntarily report fraud and abuse data.
- Identification of fraud and abuse varied significantly across Part D plans and CMS did not perform any work to determine the underlying cause of the variability.
- CMS does not collect detailed information on reported incidents, such as who committed the potential fraud and other case-specific details that could assist in followup.
- More than a quarter of Part D plans reported initiating no inquiries and corrective actions regarding incidents of potential fraud and abuse.
- CMS did not use the reported data to monitor Part D plans' fraud detection and prevention efforts.

MACS DID NOT MEET ALL PERFORMANCE STANDARDS, TWO MACS CONSISTENTLY UNDERPERFORMED, AND CMS REVIEWS OF MAC PERFORMANCE WERE NOT ALWAYS CONDUCTED TIMELY

- CMS's performance reviews of MACs were extensive, but not always completed timely.
- MACs met the majority of quality assurance standards reviewed by CMS; however, more than a quarter of unmet standards were not resolved.
- Two MACs consistently underperformed across various CMS reviews.

CMS IS MISSING THE OPPORTUNITY TO ENLIST MILLIONS OF MEDICARE BENEFICIARIES IN THE FIGHT AGAINST FRAUD THROUGH LACK OF GUIDANCE TO MACS ON UNDELIVERED MEDICARE SUMMARY NOTICES

- Over 4 million MSNs were not delivered to beneficiaries in 2012.
- Tracking and followup on undelivered MSNs is limited and varies across contractors.

Mr. PITTS. We will now begin questioning. I will begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. VITO, CMS likes to tout that it has moved away from the pay and chase system. One of the programs they have pushed to support this claim is the fraud prevention system which Congress mandated in the Small Business Jobs Act of 2010. The system is supposed to scan claims on a prepay basis and proactively flag problematic claims for review. The last report found that the Inspector General's team could not validate most of the resulted savings from the program.

Do you expect that to change this year?

Mr. VITO. I don't know the answer, but I can tell you that we will be having a report and that report will do the same things that the last year's report did and that report, I believe, will be coming out probably in the next 3 to 4 months and you should have that in front of you and you will be able to see the results of our work.

Mr. PITTS. Do you know how many claims, if any, CMS actually stopped before they were paid as a result of this system?

Mr. VITO. I do not know that answer. I am not familiar with that review. But I know that that review is ongoing and that we will have results for you.

Mr. PITTS. And do you have any ideas on how to make the system stronger?

Mr. VITO. Well, we certainly have some ideas on how to make the system stronger. One of the ways is to require Part D plans to mandatorily report this information on fraud, waste and abuse. I think once they do that, then CMS will have data that will indicate the types of fraud incidents that are occurring. It will also tell you the amount of incidents. Once you have data, then you can analyze that data and use that data in conjunction with other data to find out more information that you never had.

Mr. PITTS. Ms. King, CMS is developing a new integrity contractor called a United Program Integrity Contractor, UPIC. These contractors will focus on both Medicare and Medicaid integrity issues. And the Zone Program Integrity Contractors, ZPICs, and the Medicare Administrative Contractors, the MACs, will be folded into the UPICs. Is this an important change or are we just rearranging the deck chairs? Related, has your office seen better results from the ZPICs since they were developed out of the program safeguard contractors?

Ms. KING. Mr. Chairman, we did a review that was released last fall about the ZPICs and we found that they did have a positive return on investment. They spent a little over \$100 million and they returned or they saved about \$250 million during that time. We did make some suggestions for improvement, but we did see a positive rate of return from them.

And I think in terms of the consolidation of the program integrity contractors, the Medicare and Medicaid integrity contractors are going to be combined into one. We haven't evaluated that, but we did find fault with some of the Medicaid program integrity work. But I believe that the MACs are going to remain as they are and not be folded into that, because—while they do have some program integrity functions, one of their primary purposes is processing and paying claims, and that will remain.

Mr. PITTS. Dr. Cosgrove, do you have anything to add?

Dr. COSGROVE. No, I don't. Thank you.

Mr. PITTS. Continuing with the GAO, to help manage the program, CMS often uses cost-plus contracts. But if the contracting team at CMS writes a contract that measures the wrong things, like outputs instead of outcomes, then CMS has committed to spend millions of dollars perhaps on the wrong thing. How can this be prevented? Ms. King?

Ms. KING. You are right that they do often use cost-plus contractors under the FAR, under the Federal Acquisition Regulation, and that is one of the things that Congress authorized them to do during contractor reform. We are now looking at some of the incentives that are provided to the MACs under their contracts to see if perhaps there could be better incentives put in the contract.

We evaluated recently the HCFAC program which is the fraud and abuse control program, and it is hard to measure outcomes there because we don't know what the baseline is. We don't know what the baseline is for fraud. So that is an inherent challenge.

Mr. PITTS. My time has expired. The chair recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to ask Mr. Vito a question.

Today the OIG released the report on some of the shortcomings of the oversight of Part C, or Medicare Advantage, and it sounds to me like Medicare Advantage plans have a lot of work to do in order to improve their fight against fraud and abuse. First, can you tell me do we know how much fraud and abuse is happening in Medicare Advantage? And second, what kind of data is CMS collecting and what additional data does OIG believe should be collected?

Mr. VITO. OK. In the Part D area, CMS has not voluntarily—they have only voluntarily collected the information that we have requested. We have asked that they mandatorily report that information. That information would allow them to determine the number of fraud incidents that occurred. It would also let them know if the Part D plans had addressed those fraud incidents. By getting that information, it will provide information among all the different plans and then the plans can—then CMS can analyze that to find out which plans have higher numbers or lower numbers and they can look into the variation to see what might be going on there.

Mr. PALLONE. Well, I note from your report that while CMS did conduct some reviews on data reported under Part C, and now I am asking about Part C, the agency did not conduct follow-up with the data or look at outliers, and I think we all agree that it is not enough to simply collect the data, the agency must act on it.

So what does the OIG recommend CMS do, and how should CMS best be following up on this outlier data? And now I am asking about Part C specifically.

Mr. VITO. Well, CMS has collected, they had a contractor that identified outliers, identified inconsistency in the data, yet once they identified that, the contractor only shared that information with the plan and CMS, and CMS did not do anything with that data. They did not investigate that data. They did not review what

the reason was behind that data. Was the plan reporting information that was incorrect, or were they atypical outliers?

CMS can utilize the resources it has to do that extra step. For example, we saw some plans that had the same problem multiple years. Depending on the resources that CMS has, they can target the areas that are the most problematic, like the ones that had multiple years or the one that had three or four elements that needed to be looked at.

So it is clear to us. We gave the example, it is like taking your car in and having all the diagnostic tests run on the car, and then not using the results of that to fix the car and make sure it is safe. Basically CMS has the information, and they are not using the information to get to the best answers.

Mr. PALLONE. All right. I can ask this of any of you. CMS has a duty to continue to improve the Medicare program while keeping costs down and fostering competition. It is also critical that they take every action within their authority to alleviate fraud, waste, and abuse.

In its proposed rule issued in January, CMS proposed several provisions aimed at improving program management and integrity in the MA and Part D program, including requiring prescribers of Part D drugs to be enrolled in Medicare, providing CMS the authority to revoke an abusive prescriber's Medicare enrollment, and allowing CMS and its anti-fraud contractors to obtain information directly from pharmacies and pharmacy benefit managers that contract or subcontract with Part D sponsors.

These provisions seemed like common sense to me. But could any of you talk about the problem that Medicare faces with respect to abusive prescribing practices? How serious a problem is it, what do we know about how well Part D plans are doing dealing with improper prescribing. Any of you could answer this. I will hear from you.

Ms. KING. I don't know the answer to the question specifically, but we do have some work looking at Medicare Part D program integrity contractors at this point and seeing how their practices measure up with best practices in the private sector. So that is a question that we should be able to shed some light on. But I don't have the answer today.

Mr. PALLONE. Mr. Vito, did you want to say anything about that?

Mr. VITO. Yes. The Office of Inspector General has been looking at the Part D program for a long time. We have initially started to look at the controls that were existing in the program. We found that CMS had some controls, but they were limited and they needed to do more. We have pointed that out to them. We have a body of work that continues to show that they need to do more.

The items that you referenced, many of them are direct results of work that the OIG has identified and pointed out. We have looked at the plans and found that some of them have not reported any information, and when they have reported, it varies significantly. They are the first line.

We also then looked at the MEDICs. We found that the MEDICs could do more, that they weren't proactively analyzing data. They weren't doing a lot of the things that you asked about, such as the prescriber IDs. We found that CMS was paying claims that did not

have a valid ID, a prescriber ID. And you also referenced reports where people were writing prescriptions and they didn't have the actual responsibilities to do that.

So all these things that you mentioned here are things that the OIG has pointed out and think need to be improved and have made a lot of recommendations to have them done.

Mr. PALLONE. Thank you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Georgia, Dr. Gingrey, for five minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you very much. I would like to thank, of course, all of the witnesses for coming to allow the committee to better understand how Medicare is protecting seniors' benefits and how we can continue to reform the program to save the taxpayers money, while at the same time not overly burdening the providers. I am going to go to you, Mr. Vito, first. This is a hugely important issue that I am sure all members are hearing from their constituents, their physician provider constituents.

ICD-9, those codes are set to be replaced by ICD, International Classification of Diseases, 10 codes this October. These new codes, as you know, include thousands of new diagnosis codes, adding, of course, new burdens for providers as they attempt to abide by the law. Many providers worry that the new complexity could be a target-rich environment for auditors who might confuse an error with malintent.

I would like for you to comment on how your office thinks about this particular issue, this conversion in October. And I think that final rule has been issued to go to the ICD-10 code. The providers, the doctors, the people that I speak to in the 11th District of Georgia, northwest Georgia, would beg CMS to delay this conversion from ICD-9 to ICD-10.

Mr. VITO. Well, I would like to say that I believe that we have some planned work in that area. I cannot address your specific questions now because we need to do work to make the determination of what the issues are. But I do believe that we have work that is planned and it is in our work plan. And if you would like we could take that question back or I could have people come up and brief you from our office who are more familiar with that work.

Mr. GINGREY. Well, if you can elaborate a little bit more, Ms. King or Dr. Cosgrove, because the providers even say that even the meaningful users of electronic medical records, it was my thought that, well, that would kind of solve the problem. It would just be automatic. And they say no, no, that is not going to help at all. Do any of you have any thoughts about that?

Ms. KING. It is not an issue that we have looked at yet. All of our work really is evidence-based. And while we agree that documentation errors are a big part of what contributes to improper payments, I think we would have to look at the implementation and then assess its effects before we could comment on that.

Mr. GINGREY. Just for those that are here that may not be as up on this issue as you are, and hopefully as I am, but I mean, it is like a physician, if there is a code for a dog bite, now there would have to be a code—that code would have to be well, what was the breed of dog, and on and on and on. You get the idea. It gets a lit-

tle ridiculous. That is where you have thousands of additional codes that they have to worry about.

I have heard from my colleagues on the other side of the aisle that if we could only fix waste, fraud, and abuse, then the Medicare program would be there, it would be solvent for my children, my four adult children, and my 13 grandchildren, and we wouldn't have to do anything else. Chairman Ryan of the Budget Committee has been criticized many times for trying to come up with innovative solutions to deal with the, what, \$75 trillion worth of unfunded liability in Social Security and Medicare as we go out into the future 50 years from now. But those are obligations. They are they are on the books.

Tell me, and we can start, Ms. King, with you and work down, what are your thoughts in regard to if we could eliminate every dime of waste, fraud, and abuse, I know we can't, but if we could, do you think that that would save Medicare for the future generations?

Ms. KING. No.

Mr. GINGREY. That is fine. As Mr. Dingell would say if he were here this morning, that is fine. Dr. Cosgrove?

Dr. COSGROVE. I am going to echo the no. It is going to be a perpetual challenge to try to address waste, fraud, and abuse in the program. It is a large program and weeding it out is going to be a constant challenge. But given the demographics and the increase in technology—

Mr. GINGREY. I am going to stop you right there. I want to make one closing comment. Mr. Vito, I apologize for that, but I did start with you.

Mr. Chairman, the Administration's attempt to constrain fraud and abuse need to meet the program integrity recommendations provided by GAO. We must make sure that these attempts are not overly burdensome to providers. They do not overly penalize them for honest mistakes. It is clear, however, in my opinion, that program integrity provisions alone will not provide a sustainable Medicare program for the future. It is my hope that my colleagues take a more serious look at structural reforms for Medicare that will create a sustainable program that continues to provide health care services and peace of mind to our precious seniors.

Thank you, Mr. Chairman, and I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from the Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you for this hearing.

I want to associate myself with part of my colleague from Georgia's remarks about concerns about not placing undue burdens on our providers or mistakenly charging them with fraud and abuse. But thank you for this hearing.

I have had the experience on the MD side, but I will say that working the operations of our Part B contractors have greatly improved in the Virgin Islands and Puerto Rico, but I still do get some complaints, and I hope that ours is not one, Mr. Vito, that is underperforming and still having their contract renewed. But de-

spite the improvement, there seems to be a lot of, based on your testimony, Mr. Vito, a lot of room for improvement still.

I have a couple of questions, the first one relating to the Affordable Care Act which strengthened the Medicare program in many aspects, not only enhancing program benefits but also bolstering antifraud and abuse programs. For example, the ACA provided new provider enrollment and screening authorities to help CMS weed out bad providers and gave CMS new authority to place a moratorium on provider enrollments in areas with high fraud concerns.

So, Mr. Vito and Ms. King, can you tell us more about CMS using the new program integrity tools that were enacted in the ACA? Has the Medicare program improved as a result of these provisions in the Affordable Care Act?

Ms. KING. We looked at the provisions of the law and the new enrollment processes shortly after they were enacted and when CMS was in the process of implementing them. Since then, we have not gone back and taken another look. But I do know that CMS has used its authority to impose moratoriums on durable medical equipment and home health providers since then.

Mr. VITO. Well, the Office of Inspector General is doing the exact job that you asked about. We currently are looking at the Medicare enrollment process, the enhanced provisions that came from the ACA, and we will have a report for you hopefully by the end of this year that will give you the details on how well they are doing and if there are any areas that need to be improved.

Mrs. CHRISTENSEN. OK. So that will give us areas where CMS should continue to focus.

Mr. VITO. Yes, we will be able to tell you about how they are using their extra authorities and what results they are achieving.

Mrs. CHRISTENSEN. Are there legislative actions that any one of you would recommend Congress take in order to build upon the ACA and continue to strengthen the anti-fraud and abuse efforts in the Medicare program at this time?

Ms. KING. No, I don't think we have matters pending before Congress that we have asked you to act on in that arena.

Mr. VITO. Well, we have a couple ideas for you. We have been recommending now that CMS implement a mandatory reporting requirement for Part D, and they have not done it. They don't need to have legislation to do it, but it might be that you can help them achieve that through legislation.

In addition to that, we also think that there might be some flexibility that you want to give CMS when they award contracts. This will allow them to not be in a perpetual contracting recompetes mode and focus on the people that are underperforming and allow the people that are doing a good job to remain in the program.

This comes back to your question about the MACs. If the MACs aren't doing a good job, we want them to make sure that CMS takes action and to replace those. And CMS has done a fairly extensive job reviewing the MACs. They can do better in trying to address MACs that have underperformed though.

Mrs. CHRISTENSEN. Thank you. Ms. King, or Mr. Cosgrove, we know that Medicare Administrative Contractors or MACs have set up claims processing systems in such a way that they are able to compare claims data to Medicare requirements in order to improve

or deny claims or flag them for further review. A 2010 GAO report found that these prepayment edits saved Medicare at least \$1.76 billion in fiscal year 2010, but that savings could have been greater had prepayment edits been more widely used and better disseminated across the MACs. This seems like common sense, especially given that these prepayment edits can minimize improper payments being made in the first place.

Can you give us an estimate of how much greater savings could be if prepayment edits were more widely used and can you tell us more about your recommendations and whether CMS has implemented them?

Ms. KING. Thank you for that question. Use of prepayment edits are critically important to preventing improper payments because they do all kind of things. They screen to see if the provider is eligible to participate, if the beneficiary is eligible, and they also look at whether the service is covered by Medicare, and in some cases, they make decisions about whether the service is necessary in that situation.

I don't think we have an estimate of how much more could be saved if there were greater implementation of prepayment edits, but we did make a number of recommendations to refine the process and make it clearer.

Mr. VITO. I would like to say I would be remiss if I didn't say this. I think if Congress can consider funding the OIG fully, I think it would benefit the program. We have an eight-to-one return, so you give us \$1, we get \$8 back. We have been in a hiring freeze. We have had budget crises. We are not able to do the work that we would like to do. And if you were able to fund us, we could achieve these results. So that is one thing that I didn't bring to your attention, but I would like to. Thank you for considering it.

Mr. PITTS. The chair thanks the gentlelady, and now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. It gives me a chance to promote one of my colleagues from Illinois, Mr. Roskam's bill, the PRIME Act, which addressing the pay and chase issue which was kind of mentioned in some of the opening statements. I want to make sure I put that on the record.

Mr. Vito, using your car analogy, if one is a Cadillac where someone has payments of \$3,000 a year, one is a Buick where that payment is \$1,000 a year, and the Chevy, their payment per month is \$350 a year, and you propose cost savings of \$250 per month to all of these payments and the individual can't afford any of those cars, does that save them from losing their vehicles?

Mr. VITO. I think in the analogy that you gave it doesn't. But that was not—

Mr. SHIMKUS. No, I am just starting. I am just warming up here. So Sydne, if you would put the chart on here, so that is what Dr. Gingrey was talking about too. Ms. King and Dr. Cosgrove, and I think Mr. Vito, that is where we are at today. The red is the mandatory spending. The blue is the discretionary budget. When we have our budgetary fights and shutting down the government, it is only that blue section that we are fighting on. This is the whole debate.

And Ms. King and Dr. Cosgrove, you answered correctly, we can save a couple billion dollars here and there, but that fundamentally does not affect the solvency of our mandatory programs.

It is almost like pocket lint. Now, it is good to get that lint out of your pocket, but it doesn't fundamentally affect the solvency issue. In fact, my friend who just followed talked about Obamacare or the ACA. It took \$716 billion out of Medicare. And we had a hearing last week on Medicare D and Medicare D is changing to pay for this expansion.

So, I want to ask this question to Mr. Vito. I want to follow up. So in 2012, HHS is said to recoup \$4 billion from a program integrity effort, but roughly half—OK, \$4 billion and Medicare is \$466 billion. This is 2012 numbers. But roughly half of that was due to settlements with pharmaceutical companies. And the agency spent about \$1 billion in total costs. So that leaves about \$1 billion in actual recouped money for a year.

Can you give me a sense of what that amount is in the scope of the overall Medicare spending? If we are just using 2012, if we have \$1 billion in savings, we have \$466 billion in overall costs. It is good for a resume, but it is not really good for solving the problems of Medicare, wouldn't you agree?

Mr. VITO. Well, we are responsible for doing our work, and our work is to identify fraud, waste, and abuse, as well as to make sure the programs are running as efficiently as possible. We are doing that. And you are right, that \$1 billion—when you look at our results, we have good results and we are doing very hard work. I think, though, the point that you are trying to make is that it is a very challenging program and there is a lot of money at stake.

Mr. SHIMKUS. Well, it is challenging because it is going broke and my colleagues on the other side will not accept that premise. They just will not accept the premise that we have to actuarially make some changes.

Let me go to a specific part of the report. As part of its efforts to reduce Medicare fraud and abuse CMS relies on beneficiaries to report suspicious activity identified on their Medicare summary notices. Medicare summary notices are paper forms that summarize processed claims. Your office found that over 4 million Medicare summary notices mailed to beneficiaries were not delivered in 2012.

In the time remaining and whatever else the chairman allows us, can you talk through that issue and that problem?

Mr. VITO. Yes. An MSN is basically telling you what services that Medicare has paid for, and CMS says that it is the best defense against fraud that a beneficiary can do, is to look at their MSN. And when they look at their MSN, if they see services that they did not receive, then they can report it.

In New York last year there was a case where a beneficiary looked at the MSN, or its family, noted that the services that were being billed to them, they did not receive them, and then they started the case. The case was a \$10 million case. So when you look at MSNs, they are very critical pieces of information.

I personally got an MSN not from Medicare, thank God I am not that old, but I did note that there was some indication that I was having a procedure that is only provided to women. But I looked

at that and then I was able to call that in and then they resolved that.

So that is one of the best tools. And if just one beneficiary looks at that and it results in \$10 million, that is a great savings.

Mr. SHIMKUS. Can you speak to the 4 million in the report?

Mr. VITO. Yes, 4 million is a small number compared to the total.

Mr. SHIMKUS. No, about them not being mailed out.

Mr. VITO. Yes, I can. When we started this review, CMS had no idea on the number of MSNs that were not being delivered. They had no total. We actually went to each MAC and asked each MAC to tell us how many MSNs they had that weren't getting to where they needed to be. This is important because without knowing that, you don't know what the extent of the problem is. That is why we went out and did this.

This had already been pointed out to CMS two times previously in annual reports, and CMS, they thought about doing it, but they found out that it costs money to have some people at the MAC doing this, so they made a decision not to do that.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Florida, Mr. Bilirakis, for 5 minutes for question.

Mr. BILIRAKIS. Thank, you, Mr. Chairman. I appreciate it.

The first question is for the panel. The IRS does an estimate of how much money they should be collecting and compares that to how much money they actually collect. This gives them a sense of how many people are not complying with the Tax Code, or are tax evaders. We report on how much money is recovered from fraud arrests, but without any measurement of the fraud problem, it is hard to know how much of a difference we are making.

Have you ever done an official estimate of fraud in the Medicare program and has CMS ever done an official estimate, for the panel? We will start with Ms. King.

Ms. KING. We have not. Part of the difficulty is it is hard to measure what you don't know about. If, for example, I submit a claim for a service that was never provided and that claim looks totally legitimate, it is going to be paid. But that is, in fact, a fraudulent claim. So there are things like that that happen that are not captured.

We have noted the lack of a reliable estimate of fraud in Medicare, and urged CMS to work on it, and I believe that they are starting on a pilot to measure the extent of fraud in home health. It is a difficult undertaking, but they are working on it.

Mr. BILIRAKIS. So when do you expect the pilot to be rolled out?

Ms. KING. They talked about it in their most recent report that was released within the past few weeks, the health care fraud and abuse control annual report. I can't speak for them because I don't know their exact plans, but I would imagine it would take some time.

Mr. BILIRAKIS. Dr. Cosgrove. I am sorry. Do you want to finish, ma'am? OK. Dr. Cosgrove.

Dr. COSGROVE. Thank you. I don't have anything to add to Ms. King's statement.

Mr. BILIRAKIS. OK. How about Mr. Vito?

Mr. VITO. I think fraud is only when it is determined by a court of law. That is when fraud occurs. You could have indications of fraud, but it is only when it is finalized and the case has been adjudicated. I think that what we are trying to say is that CMS needs—they have data, and they need more data; and when they have that data, they need to analyze that data; and that would help them identify what is going on in their programs.

For example, in the Part D area, if they got information on what the plans are reporting as incidents of potential fraud, then they can look behind that. They can use that data to compare it to fraud areas to see if the Part D program is actually doing a good job in detecting and preventing fraud, waste, and abuse. They can compare it to others.

So for me, I think you are asking about data and the use of data to make informed decisions and to target your work; and that is what we are advocating with CMS, that they use the data they have and maybe enhance some more data so that they would be able to target their resources in the best manner.

Mr. BILIRAKIS. Thank you. Next question. Many of the monetary criminal and civil penalties for fraud were established in the 1980s and 1990s. Do you think these monetary penalty amounts should be updated, Ms. King?

Ms. KING. I don't have any expertise to comment on that, sir.

Mr. BILIRAKIS. OK. Dr. Cosgrove?

Dr. COSGROVE. We have not done any work in that area.

Mr. VITO. I am not a lawyer or a prosecutor. I can tell you, though, we have those people and we would be certainly willing to answer your question or meet with you to talk about your question.

Mr. BILIRAKIS. Well, that is fine, but if the penalties were established in the 1980s and 1990s, that was a heck of a long time ago; so I would think it would need updating. But, yes, I would like to get with you, Mr. Vito, on that.

Mr. VITO. I think we could certainly meet with you.

Mr. BILIRAKIS. OK. Next question. GAO has Medicare listed on their high-risk programs. Medicare has probably been on the high-risk list longer than some of my staffers have been alive. Has CMS done anything recently or in the foreseeable future that would move Medicare off the high-risk program list? Who would like to respond first?

Ms. KING. I will, sir. We are in the process of updating our high-risk report for the next issuance. Medicare is inherently complex, it is an expensive program. It is, as noted, taking up a larger share of the Federal budget and of national spending each year; so it is an intrinsically complex program, but we are in the process of evaluating whether it should continue to be on the high risk list. It has, however, been there since 1990, since the very beginning of our high-risk list.

Mr. BILIRAKIS. Thank you. Thank you. Dr. Cosgrove.

Dr. COSGROVE. I just want to comment on one of the efforts that CMS has underway regarding Medicare Advantage, the part C program. It is in the process of collecting encounter data from plans so that we better understand the services that they are providing to beneficiaries. I think their immediate plans are eventually to use this to improve the risk adjustments, the adjusting payments for

health status. But the data has opportunities to go well beyond that and allow CMS to do a better job of oversight, and we currently have work on CMS's plans and efforts right now that we hope to be able to report later on in this spring.

Mr. BILIRAKIS. Thank you. Mr. Vito, would you like to comment?

Mr. VITO. I think that the Medicare program is certainly a complex program, and a large amount of resources at the OIG are focused on looking at that program. We have results that continue to point out that there are things that can be done. We have shown where better use of legislation and policy rules have resulted in savings that have been achieved of \$19 billion of the recommendations that the OIG has made. So we think that it is a very challenging program. We think we need to devote a lot of resources on that program in every way, whether it is evaluation, auditing or investigating, and we could certainly use more funds to do that, but we definitely believe it is a challenging program; and we are going to do our best to keep our eye on it.

Mr. BILIRAKIS. Mr. Chairman, I know my time is expired, so I will yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the first round. We will go to one follow-up per side, I will recognize myself 5 minutes for that purpose.

Private insurers and HMOs face many of the same challenges that Medicare does in managing its providers. In August of 2012, CMS announced a public private partnership. Many in Congress applauded this overdue collaboration, but now about a year and a half later, private plans in Medicare have shared only the most basic information.

How can CMS contractors be allowed to better cooperate and benefit from their knowledge of suspect and untrustworthy providers, for both Ms. King and Mr. Vito?

Mr. VITO. OK. Well, in our Part D report, we recommended that CMS share the information on the possible fraud issues with plans as well as law enforcement. So we think there is benefit to continued sharing. You have to be careful what information you share, but I think there is a way to do this; and our office has that partnership; and we are working through that, and we would be able to, again, take any question that you have. I am not the expert on that, but we do have people in our office that would be willing to come and meet with you or handle any question you might have on that.

Mr. PITTS. Any other comments? Dr. Cosgrove.

Dr. COSGROVE. Yes, I guess I would just like to mention the Medicare Advantage encounter data that CMS is currently being collected because I think that will give CMS a broader view of what is going on and what is becoming a very significant part of the Medicare program, a much broader view than even one plan has. And those data, I think, hold a great deal of promise if CMS follows through and analyzes and uses those data.

Mr. PITTS. How many contracting officers are there at CMS, and are they required to be subject matter experts in their areas of contracts? And what type of training do they receive? And how are they held accountable? How is their performance assessed? Ms. King?

Ms. KING. That is not an issue that we have looked at, and I don't know how many contracting officials there are there.

Mr. PITTS. Mr. Vito, do you know?

Mr. VITO. Well, we are in the process now of looking at CMS's contracting, and we are trying to provide you with a landscape look at how many dollars they have, the type of contracts and who is administering the contracts. In addition to that, we are also going to be looking at how the contracts have been closed or not closed; so we hope within the next, by the at the end of this year, that we will have a report that will provide some detailed information on just the general information about CMS and its contracting.

Mr. PITTS. CMS has a range of contracting vehicles at its disposal. Some are very incentive-driven. Some are very flexible. Some are just cost-plus contracts. Can you talk a little bit about what parts of the contracting process could be streamlined and modernized in order to hold contractors more accountable and achieve better return on investment for taxpayers?

Mr. VITO. Well, I will not be able to answer that right now. We have current work underway that also looks at contracting and how the contracting was handled in the ACA area. We hope that when we get that information, it will provide some of the answers to some of the questions that you have; and that is ongoing as well.

Ms. KING. The biggest contractors at CMS now are the MACs, the Medicare administrative contractors, and we did an evaluation of the implementation of contractor reform a few years ago; and there is a rigorous process set up to evaluate the contracts, and the IG has done more recent work on that and recommended some improvements; but they do have, under the FAR, under the Federal Acquisition Regulation, an intensive process for awarding the contracts and also for measuring the contracts and awarding fees under it.

We are also looking, though, at whether they could be using some additional or different incentives in the program to drive better performance, and we should have a report on that later this year.

Mr. PITTS. All right. The chair thanks the panel, and now I recognize the ranking member 5 minutes for follow-up questions.

Mr. PALLONE. Mr. Vito, I wanted to go back to my questions about Part D, specifically the CMS proposed rule to strengthen Part D with regard to fraud; and I have heard some concern that requiring physicians who wish to prescribe drugs to Medicare beneficiaries actually be enrolled in the program is too much bureaucracy and interference for physicians, and I just wanted to get your assessment of that.

Do you believe that it is overly burdensome to require a physician writing prescriptions for which Medicare will pay be subject to some basic enrollment standards? What is your opinion on that?

Mr. VITO. I think that we had previously made that recommendation; and if we did, that means that we think it is appropriate to do. I think it is always a challenge to find the right balance, and that is what we seek to do here to make sure that the program is properly safeguarded and that there is not too much burden. So those are the things that we consider when we make a recommendation.

Mr. PALLONE. All right. I appreciate your insight. As I mentioned in my opening statement, this is an important topic, and that is why I introduced the Part D Prescription Drug Integrity Act, and I think we can and have to do more in the Part D program to help address the prescription drug abuse epidemic.

I have no further questions, Mr. Chairman. Thank you.

Mr. PITTS. Chair thanks the gentleman. Members do have other questions. We will submit them to you in writing. We ask that you promptly respond to those questions in writing. And I remind members that they have 10 business days to submit their questions for the record. Members should submit their questions by the close of business on Tuesday, March 18.

You have been addressing a very important issue. We thank you very much for your work and look forward to continue to work with you.

Without objection. The subcommittee is now adjourned.

[Whereupon, at 11:10 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we examine the operating structure of Medicare—the relationships between the Medicare program and its contractors that are essential to ensure that the benefits and care our seniors depend on are delivered as intended.

As we have warned many times, the financial sustainability of Medicare is under serious threat, putting the access to and quality of care for current and future seniors in jeopardy. The Medicare Part A trust fund is expected to run out as soon as 2017, while the cost of the entire Medicare program is projected to reach a trillion dollars each year by the end of the decade.

This is a problem that requires more than better program management or combating waste, fraud, and abuse, but that does not mean that the important work of improving program effectiveness should be neglected. We must safeguard every Medicare dollar to keep the promise of quality health care to our nation's seniors and future generations.

The Government Accountability Office repeatedly has warned that the Medicare and Medicaid programs face a particularly high vulnerability to fraud, due to their "size, scope, and complexity." The Medicare program receives 4.5 million claims per day from 1 million providers, who supply an extraordinarily wide range of services that must by law be reimbursed within 30 days. The program therefore faces a substantial challenge to ensure that its funds are used appropriately.

Medicare is implemented and audited by a patchwork of different contractors, established by succeeding waves of legislation over the past halfcentury. Its approach is loosely known as "pay-and-chase": one set of contractors fulfills claims, while others are then charged with following up to retrospectively investigate and identify payments that have been inappropriately made.

In processing millions of claims, a tremendous amount of data gets collected, but information regarding payments is often fragmentary and scattered amongst separate organizations. As a result, oversight is poorly coordinated. The effectiveness of CMS contractors could be greatly enhanced by cooperation, but this is seriously impeded by federal law—sometimes with good reason, but in too many instances this is not the case.

The purpose of this hearing is to reexamine existing arrangements and to further the discussion regarding what can be done to enhance contractor performance, accountability and efficiency. While most of this effort requires leadership and commitment from CMS, I hope that our witnesses today will take the lead in this discussion and that outside partners and friends of the Medicare program will subsequently feel encouraged to contribute their own recommendations and suggestions. This is just one small, but important step in securing the future of the Medicare program and ensuring that every taxpayer dollar spent through this program is used most effectively. Let's work together to keep the promise to our seniors.

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